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PPO Plan

Plan Design Feature	Member Cost Sharing: (In-Network)	Member Cost Sharing: (Out of Network)
Annual Medical Deductible	\$500 - Individual \$1,000 - Family	\$500 - Individual \$1,000 - Family
Annual Pharmacy Deductible	\$100 - Individual \$200 - Family	\$100 - Individual \$200 - Family
Annual Out of Pocket Maximum, Medical & Pharmacy Combined, (includes all copays, deductibles and coinsurance)	\$5,000 -Individual \$10,000 - Family	\$5,000 -Individual \$10,000 - Family
Out of Network Co-Insurance	Not Applicable No Out of Network Coverage	20% coinsurance, after deductible
Routine Annual Exam	\$0 copay	\$0 copay
Routine Eye Exam, every 24 months	\$0 copay	\$0 copay
PCP Visit (Including OB-Gyn)	\$20 copay	20% coinsurance, after deductible
Specialist Visit	\$60 copay	20% coinsurance, after deductible
Mental / Behavior Health Visit	\$20 copay	20% coinsurance, after deductible
Urgent Care Visit	\$20 copay (Pending Approval from DOI)	20% coinsurance, after deductible
Short Term Therapy Visit (Physical or Occupational Therapy) and Cardiac Rehab Visit	\$20 copay	20% coinsurance, after deductible
Chiropractic Visit	\$20 copay	20% coinsurance, after deductible
Diagnostic Lab and X-Ray	Covered in full after deductible	20% coinsurance, after deductible
Imaging (CT, PET, MRIs)	\$100 copay after deductible	20% coinsurance, after deductible
Emergency Room (waived if admitted)	\$100 copay after deductible	20% coinsurance, after deductible
Day Surgery	\$250 copay after deductible	20% coinsurance, after deductible
Ambulance Transportation	Covered in full after deductible	20% coinsurance, after deductible
Inpatient Care	Low Cost Hospital \$275 copay High Cost Hospital \$1,500 copay after deductible	20% coinsurance, after deductible
Durable Medical Equipment and Prosthetic Devices	20% coinsurance, after deductible	20% coinsurance, after deductible
RX - Retail	Tier 1 \$10 copay Tier 2 \$30 copay Tier 3 \$65 copay after annual pharmacy deductible	Tier 1 \$10 copay Tier 2 \$30 copay Tier 3 \$65 copay after annual pharmacy deductible
RX - Mail Order	Tier 1 \$25 copay Tier 2 \$75 copay Tier 3 \$165 copay after annual pharmacy deductible	Tier 1 \$25 copay Tier 2 \$75 copay Tier 3 \$165 copay after annual pharmacy deductible
Hearing Aids Coverage for all members	Hearing aid coverage, limited to \$2,000 for one hearing aid per hearing-impaired ear every 36 months	20% coinsurance, after deductible (and above the allowable amount)
Fitness Reimbursement	\$150 per subscriber per year	\$150 per subscriber per year
Weight Watchers Reimbursement	\$150 per subscriber per year	\$150 per subscriber per year